STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155649	A. BUILDING 00 B. WING	04/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey Dates: April 22, 23, 24, 25, & 26, 2012 Facility Number: 010478 Provider Number: 155649 AIM Number: 200197620 Survey Team: Mary Weyls RN TC Laura Brashear RN Teresa Buske RN Census Bed Type: SNF/NF: 73 SNF: 5 Total: 78 Census Payor Type: Medicare: 10 Medicaid: 48 Other: 20 Total: 78 These Deficiencies reflect State Findings cited in accordance with 410 IAC 16.2 Quality review completed on May 4, 2012 by Bev Faulkner, RN	F0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation and record review, the facility failed to ensure personal privacy to 1 of 4 residents observed during random observations, receiving blood sugar testing or injections .[Resident # 104] Finding includes:	F0164	1. The one resident involved in the alleged deficient practice was not negatively affected by the practice.2. All the residents in the facility have the potential to be affected by such a practice as the all receive care to a certain extent. 3. Residents will be surveyed once per month for 3 months regarding privacy during care. Any concerns will be dealt	05/26/2012

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	On 4/24/12 at 12:00 p.m., Resident #104 was observed to be taken to her room in a wheelchair by LPN #1. The resident was positioned at the end of her bed on the door side of the room, facing the door and hallway. The door to the room and privacy curtain were not closed to provide privacy. The LPN performed an accucheck,(fingerstick blood sugar test), exited the room, prepared an insulin injection, returned to the resident in the room and administered the injection. During the procedure, the resident's roommate [not in the room] had a visitor that came in the room, squeezed past the resident, seated in the wheelchair, to the other side of the room. A facility document titled "Resident Rights Guidelines," dated 2006, provided by the Administrator on 4/26/12 at 4:00 p.m. included, but was not limited to, "Close the door to the room if appropriate. Screen the resident for privacy." 3.1-3(o) 3.1-3(p)(2)		with on a case by case basis to include among other things staff re-education and monitoring. Nursing Staff will be inserviced on Privacy During Patient Care.4. The D.O.N. or her designee will do documented patient care audits to monitor Privacy 3 times per week for 30 days then 1 time per week for 6 months. Audit results will be monitored weekly by the Executive Director for compliance. The Quality Assurance Committee will review the audit results monthly for 6 months to determine compliance.	

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F0315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation and record review, the facility failed to provide services to prevent urinary tract infection to 1 of 2 residents in random observations with an indwelling Foley catheter in that the drainage bag and tubing were not kept below bladder level to prevent back flow of urine or from contact with the floor to prevent contamination. [Resident #35] Finding includes: 1. On 4/23/12 at 10:30 a.m., Resident #35 was observed to be transferred from bed to a wheelchair with a mechanical lift. The resident was observed to have an indwelling urinary catheter. CNAs #2 and #3 were observed to place the urinary drainage bag on top of the resident in bed while positioning the lift sling under the resident. The bag remained	F0315	1. The one resident involved in the alleged deficient practice was not negatively affected by the practice.2. Residents with indwelling catheters were reviewed for proper bag placement, tubing placement and dignity bags. No other residents were affected by such practice.3. Nursing Staff will be inserviced on Catheter Care and Prevention of Urinary Tract Infections.4. The D.O.N. or her designee will do documented patient care audits to monitor Catheter Care and Care during transfers 3 times per week for 30 days then 1 time per week for 6 months. Audit results will be monitored weekly by the Executive Director for compliance. The Quality Assurance Committee will review the Audit results monthly for 6 months to determine compliance and need for continued Audits or education.	05/26/2012

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	on top of the resident while attaching the sling to the lift and was attached to a loop of the sling, above bladder level, while transferring the resident from the bed to the wheelchair. After positioning the resident in the chair, the catheter bag was placed on top of a large bed pillow, positioned on the foot rests of the wheelchair. The drainage bag was not contained in a dignity bag. 2. On 4/24/12 at 2:35 p.m. Resident #35 was observed in bed, in low position. The urinary drainage bag and tubing were observed to be in contact with the floor. The drainage bag was observed not to be contained in a dignity bag. Resident #35's clinical record was reviewed on 4/26/12 at 5:57 p.m. The resident's diagnoses included, but was not limited to, history of chronic neurogenic bladder and urinary tract infections. A plan of care with most recent date of 4/5/12 addressed the problem of high risk for urinary tract infection due to indwelling catheter. Approaches included, but were not limited to, "Ensure catheter tubing and drainage bag are properly positioned to prevent urinary back-flow or contamination."			

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	A facility policy titled "Catheter Associated Urinary Tract Infection (CAUTI) Prevention," dated 2012, provided by the Administrator on 4/26/12 at 4:00 p.m. included, but was not limited to, "PURPOSE: To ensure appropriate technique in the care and maintenance of Foley catheters. ...VIII. Maintain unobstructed urine flow by keeping the collection bag below the level of the bladder and the tubing free of kinks. ...IX. Keep the collection bag and tubing off of the floor...." 3.1-41(a)(2)			

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F0322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation and record review, the facility failed to check gastrostomy tube placement to prevent aspiration pneumonia for 1 of 2 random observations of residents utilizing gastrostomy tubes. [Resident #1] Finding includes: On 4/23/12 at 12:00 p.m., LPN #1 was observed to administer medications to Resident #1 through a gastrostomy [g-tube] tube. Prior to administering the medications the nurse was observed to place a piston syringe into the tube and flush the tube with approximately 30 cc of water while auscultating the abdomen with a stethoscope. The nurse removed the plunger from the syringe and continued administering the medications and water flushes. Resident #1's clinical record was	F0322	1. The one resident involved in the alleged deficient practice was not negatively affected by the practice.2. All residents involved in the alleged deficient practice was not negatively affected by the practice.3. Licensed Nursing Staff will be inserviced on G-Tube care and Med. Administration through G-Tubes.4. The D.O.N. or her designee will do documented patient care audits to monitor G-Tube care 3 times per week for 30 days then 1 time per week for 6 months. Audit results will be monitored weekly by the Executive Director for compliance. The Quality Assurance Committee will review the Audit results monthly for 6 months to determine compliance and need for continued Audits or education.	05/26/2012

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	reviewed on 4/26/12 at 2:22 p.m. The resident's diagnoses included, but not limited to, esophageal stricture, stomach dysfunction and hiatal hernia. A current physician's order, dated 8/5/10, was noted on the April, 2012 recapitulation of physician's orders to check g-tube placement with 10 cc air bolus before feeding. A facility policy titled, "Medication Administration through an Enteral Tube," [no date] provided by the Administrator on 4/26/12 at 4:00 p.m. included, but was not limited to, "13. Check the placement of the naso-gastric or gastrostomy tube in accordance with facility policy. b. Insert a small amount of air into the tube with a syringe and listen with stethoscope for placement. 14. Flush the feeding tube with at least 30 ml [milliliters] of preferably warm water before and after medications are administered." 3.1-44(a)(2)			

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F0431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medications were stored in a manner to permit only authorized	F0431	1. No residents were found to have been affected by the alleged deficient practice therefore there were no immediate corrective action necessary to a specific	05/26/2012

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	personnel access for 1 of 2 medication rooms in the facility. This had the potential to affect 36 residents residing on the South nursing unit. Finding includes: On 4/26/12 at 3:00 p.m., the South unit medication storage areas were observed with LPN #9. During inspection of the locked medication room, LPN #9 was asked where medications to be returned to the pharmacy for credit were stored. The LPN indicated they were placed in a plastic tote located under a counter top in the nursing station. The LPN indicated pharmacy picks up the medications two times daily. On 4/26/12 at 4:39 p.m., a plastic storage tote was observed under the counter top in the South nursing station. Copies of physicians' telephone orders were observed in the tote. LPN #11 was interviewed. The LPN indicated medications to be returned to pharmacy were placed in the tote and she believed pharmacy comes in each shift and picks up the medications. The nursing station was observed with an open entryway from the halls of the unit. No door was observed to the nursing station.		resident.2. No residents were found to have been affected by the alleged deficient practice only a potential therefore there were no immediate corrective actions necessary to specific residents.3. Licensed Nursing Staff will be inserviced on proper medication storage. Medications will be securely locked in a medication cart or locked in the medication room adjacent to the South Nurses Station including those medications that are due to be picked up for return to the pharmacy. On the North Nurses Station a cabinet with a lock will be utilized for the medications due to be picked up for return to the pharmacy. 4. The Executive Director will inspect the nurses stations daily for 30 days to assure compliance then 3 times per week for 30 days and document finding to assure compliance. Findings will be reported to the Quality Assurance Committee for 6 Months.	

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	On 4/26/12 at 4:45 p.m., LPN #8 was interviewed. The nurse indicated pharmacy comes in two times a day Monday through Saturday and picks up medications. The nurse indicated pharmacy does not come to the facility on Sundays. A facility policy titled "Return Medication to the Pharmacy and Credits" dated 5/1/10, included, but was not limited to : "This Policy 8.1 sets forth procedures relating to medication returns and credits. PROCEDURE 1. Facility may return a resident's medication to Pharmacy to receive credit if permitted by and in accordance with Applicable Law and Omnicare's returned medications policy. ..6. Facility should securely store the medications to be returned to Pharmacy until they are picked up by Pharmacy driver. ..." 3.1-25(m)			

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation and record view, the facility failed to ensure	F0441	1. None of the residents were found to have been affected by	05/26/2012

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	proper hand hygiene was performed during 2 of 2 observations of residents with G tubes (Residents #29 and #1) and during 2 of 2 observations of residents with indwelling urinary catheters (Residents #11 and #35). The facility failed to ensure equipment used for blood sugar testing was decontaminated in accordance with facility policy for 1 of 2 residents observed (Resident #104). This involved 2 of 4 licensed personnel (LPN's # 1 and #8) and 4 of 6 CNAs observed providing care (#'s 2, 3, 4, and 6). Findings include: 1. On 4/26/12 at 10:17 a.m., LPN #8, while wearing gloves, administered Fibersource HN feeding solution through Resident #29's gastrostomy tube. Without removing the contaminated gloves, the LPN repositioned the resident, adjusted the blanket and touched the handle of the hand sink in the resident's room to rinse equipment.		the alleged deficient practice therefore there were no immediate corrective action necessary to a specific resident.2. All residents with indwelling catheters and gastronomy tubes were assessed and no residents were found to have been affected by the alleged deficient practice only a potential there fore there were no immediate corrective actions necessary to specific residents.3. Nursing Staff will be inserviced on G-Tube care and Med. Administration through G-Tube, Catheter Care and Hand Washing/Infection Control. Nursing Staff were inserviced on the proper procedure for Disinfecting the Glucometer after use.4. The D.O.N. or her designee will do documented patient care audits to monitor Catheter Care, Care during transfers, and Care during G-Tube procedures 3 times per week for 30 days then 1 time per week for 6 months for proper handwashing practices. The D.O.N. or her designee will do documented Glucometer Audits to assure proper disinfecting is taking place 3 times per week for 30 days then 1 time per week for 6 months for proper disinfecting procedures. Audit results will be monitored weekly by the Executive Director for compliance. The Quality Assurance Committee will review the Audit results monthly for 6	

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	155649	A. BUILDING 00 B. WING	04/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	210 STATE HWY 43 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. On 4/2512/ at 12:40 p.m., Resident #11 was observed to be transferred from the wheelchair to the bed by CNAs #4, #5, and #6. The CNAs transferred the resident utilizing the mechanical lift. Resident #11 was observed to have a Foley (urinary) catheter in place. CNA #4 with gloves on was observed to handle the resident's Foley catheter bag and tubing. Without changing the contaminated gloves, CNA #4 was observed to move the resident's wheelchair and close the bathroom door. The CNA then removed the contaminated gloves and wash her hands. CNA #6 with gloves on was observed while removing the resident's slacks to handle the Foley catheter bag and tubing. Without removing the contaminated gloves, CNA #6 was observed to position the resident's feet on pillows and adjust the resident's covers prior to removing the gloves and washing her hands. 3. On 4/23/12 at 10:30 a.m., CNAs #2 and #3 were observed to transfer Resident #35 from the bed to wheelchair with a mechanical lift. Before removing gloves and washing hands, the CNAs handled the		months to determine compliance and need for continued Audits or education.	

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	resident's indwelling Foley catheter bag and tubing, positioned a lift sling under the resident, attached the sling to the lift, moved the lift from the bed to wheelchair and positioned the resident in the chair. Wearing the same gloves utilized in handling the catheter bag and tubing during the transfer, the staff moved the wheelchair, moved the mechanical lift, opened a dresser drawer, combed the resident's hair, applied hair spray and obtained a dignity bag for the catheter from the roommate's side of the room. 4. On 4/23/12 at 12:00 p.m., LPN #1 was observed to administer medications to Resident #1 through a gastrostomy tube [g-tube]. While wearing gloves, the nurse handled the g-tube, the syringe positioned in the tube to administer medications and water and with the same gloves opened the bathroom door, rinsed the syringe in the bathroom sink returned to the resident's bedside, opened a plastic bag and returned the syringe to the bag before removing the gloves worn to handle the g-tube. 5. On 4/24/12 at 11:55 a.m., LPN #1 was observed to perform an accu check (finger stick blood sugar test) on Resident #104. The nurse entered			

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	the resident's room with a zippered nylon type material case containing a vial of test strips. The nurse laid the meter and opened case on the resident's bedside table. LPN #1 put on a pair of disposable gloves, performed the finger stick, placing a drop of blood on the test strip that was inserted into the meter and placed the meter on the table. With the gloves on worn to swab and perform the finger stick, the nurse picked up the bottle of test strips placed in the open the case. The nurse then removed the gloves, picked up the meter, placed it inside the case, exited the room and placed the case on top of the medication cart. The nurse removed a Clorox wipe from the cart, wiped the exterior of the meter and immediately returned it to the case, zipped the case, and put in a drawer of the cart. A facility policy titled, "Glucometer Decontamination," dated 2012, provided by the Administrator on 4/26/12 at 4:00 p.m. included, but was not limited to, "PURPOSE: To implement a safe and effective process for decontaminating glucometers after use on each resident. Since glucometers may be contaminated with blood and body fluids as well as other pathogens			

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	...this facility has chosen a disinfectant wipe that is EPA registered as tuberculocidal; therefore it is effective against HIV, HBV, and a broad spectrum of bacteria. ...PROCEDURE: I. The nurse will obtain the glucometer along with the wipes and place the glucometer on the overbed table on a clean surface, e.g., paper towel, wax paper. Cleaning and disinfecting the glucometer: II. After performing the glucometer testing, the nurse shall perform hand hygiene, don gloves, and use the disinfectant wipe to clean all external parts of the glucometer. A specific amount of wet contact time is not required for cleaning. III. Gloves shall be removed, hand hygiene performed, and clean gloves will be donned. IV. A second wipe shall be used to disinfect the glucometer, allowing the meter to remain wet for the contact time required by the disinfectant label. V. The clean glucometer will be placed on another paper towel. VI. Gloves will be removed and hand hygiene performed. VII. The glucometer will be placed in the appropriate storage location until needed." Manufacturer's directions for the cleaner/disinfectant "Clorox Germicidal Wipes for Medical			

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	Equipment Surfaces" utilized in the facility for the blood glucose meters, provided by the DON on 4/26/12 at 4:15 p.m. included, but was not limited to, "Broad Surface Coverage and Wet Times: Tested to keep a 4 foot squared wet for 2.5 minutes, achieving nearly all registered bacteria and virus dwell times with a single application." The information included a list of Bacteria, Viruses, and Fungi and kill times to keep surfaces wet ranging from 30 seconds to 5 minutes." A facility policy titled "Hand Hygiene," dated 2012, provided by the Administrator on 4/26/12 at 4:00 p.m. included, but was not limited to, "PURPOSE: To decrease the risk of transmission of infection by appropriate hand hygiene. Handwashing/hand hygiene is generally considered the most important single procedure for preventing healthcare associated infections. ...I. Handwashing When hands are visibly dirty or contaminated with proteinaceous material, are visibly soiled with blood or other body fluids, ...after providing care to a resident with a spore-forming organism (e.g., C. difficile), perform hand hygiene with either a non-antimicrobial soap and			

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	water or an antimicrobial soap and water. ..." 3.1-18(l)			